EOHHS Task Force
February 29, 2016
1:00pm -3:00pm
301 Metro Center Boulevard
Warwick RI

Attendees: Kathy McKeon, Linda Mahoney, Kathleen Kelly, Janet Marquez, Nicholas Oliver, Kathy Heren, Catherine Taylor, Jim Nyberg, Virginia Burke, Maureen Maigret, Mike Burk, Dacia Read, Kim Paull, Denise Achin, Jessica Mowry, Deb Garneau, Chris Gadbois, Cristina Amedeo, Lynn August, Mike Walker, Sharon Terzian, Jennifer Reid, Ann Martino, Lauren Lapolla, Tom Izzo, Michael Cancilliere, Anne Mulready

I. Welcome – Senator Tom Izzo

Sen Izzo: Good Afternoon. I would like to welcome everyone to the meeting. There are a number of items on our agenda today to get through. One thing I want to say is we do develop an agenda internally at EOHHS and work on the needs and interactive communication with you all. I am feeling very confident with EOHHS's attention to detail to try to bring you all the information that is important to know, and useful for you all in your daily lives.

II. Introduction – Kim Paull, Director of Data & Analytics

Kim Paull: I am the Director of Analytics at EOHHS and I am new to the role. My job here today is to say hello, nice to meet you, and explain a bit about this role: My work is to orchestrate and analyze analytics in an organized and coordinated way. The point of having an executive office is so that we, and our sister agencies, can pool ideas and resources – and I am doing that with analytics. In the near future we want to bring together groups that have a hand in data and analytics and meet monthly to be sure we are all on the same page – talk in a low-tech/ high-resource way. The second thing we want to do is to build a tool to understand what it means if a client is traveling through the various systems – everything from putting our staff together, to actually putting our resources together so that we can support strategic analytic work. I do work directly at EOHHS, but we work with our sister agencies and partner with the Office of the Health Insurance Commissioner, with HealthSourceRI, and with the Department of Corrections certainly. That's the elevator version, but happy to take questions.

Christine Gadbois: I was excited to see the All Payer Claims Database (APCD) information, but I could only see information on the twitter feed that you all had disseminated and posted, when do you expect that providers can start to access that information so that when we take on increasing risk for our populations?

Kim Paull: Hope to have data out that is useful for providers around the end of March early April. Bigger picture, APCD is known in our state as HealthfactsRI. It's something that standardizes claims, organizes them, and applies analytic tools on top of them to tell stories and understand the data. I want to be clear it is not identified data – no names, SSNs, addresses in this database. We can track individuals over time, but it is claims data from every payer in the state. We want to put this data to use comprehensively overall. This is a

huge month for data in RI.
Ann Martino: We are about to enter a new era for HHS with UHIP, which goes beyond health services, but will allow us to put information across programs, and that with HealthfactsRI RI we will have more information than we have ever had.
Kim Paull: I will say, I am interested in transparency, we will always have free public data on health.ri.gov/facts. The data most useful will be for purchase, as it costs money to put it together – it is a nominal fee relative to the amount of work done for the data – but reasonable priced.

Virginia Burke: I love that you said it was a big data month in RI. I found HealthfactsRI on the Department of Health website – do they operate it?
Kim Paull: HealthfactsRI is an interagency project, Dept. of Health, OHIC, HSRI and Medicaid EOHHS. Health releases the regs, health hosts the site, and reviews applications for data that would be used publicly. The director chairs the Review Release Board.
Jim Nyberg: Does that include Medicare advantage?
Kim Paull: Yes only things not in there are anyone with less than three thousand covered lives, and dental. There are nine insurance companies in RI that cover more than three thousand lives.

Kathleen Kelly: Can you tell me how far an entity could drill down into the data? Can you pull out information about people receiving Long Term Care (LTC) services?
Kim Paull: Yes. If a provider submits a claim to an insurer in the database, it is in the database. Anything that is private pay, not through an insurance company, not in the database. Anything in the claim is fully in there. There are different levels of access to the data – if you want to go in for the full thing you would apply for level three access. Level one is publicly available on the website, two is a bit more, and three is the full claims extract. Level three is more expensive, and does have to go through the data release review board application for privacy purposes, but it is there. You can also see groupings of claims without a lookup table.

Jim Nyberg: What is the lag time for the data?
Kim Paull: The bottom line is about 6-9 months, the data is updated quarterly. We are not using it to monitor real time admissions, but still good data as far as health care goes. We will have updated data on June 30, 2015 in there at this time.

Virginia Burke: You can get the entire claim, but I assume you take out identifiers?
Kim Paull: Yes, we have hired a company that all the payers submit demographic information to – they scramble it entirely with new codes – and sends it back to us to put in the system. We have the most privacy protections, but still trackable by person – meaning if I were to switch from United to BCBS to another I would still have all information in the system.

Senator Izzo: Are there personnel in place to do the analysis? In the past they have built information warehouses and the problem was there was no one to do the analysis. Are

there folks now?
Kim Paull: Yes, every state agency especially that have been partnered in this, has what we call "super users." We have worked with the data for a while, who know the software package and there is a fair amount of training that goes into being a super user. We designed it to be a self-service model, the software works well, but we haven't trained enough folks just yet to be there. HealthfactsRI is a powerful tool we can now use. CMS said every state has to list a Medicaid access to care report – that require many deep down pulls of data. What used to take months and hundreds of dollars in resources, we can now do in few hours.

Christine Gadbois: To clarify, there will be some level of access that the public will have in terms of accessing some level of data but if you want to drill down for specifics, you have to issue a request and pay for it?
Kim Paull: Yes and the data on the public website now is free and always will be free. Level 2 and Level 3 are for purchase. Level 2 data with ten different qualifiers (ish) in a higher sense.
Christine Gadbois: If I want to know how many people with heart disease running through emergency rooms that will be on the site, but if you wanted to query a little different on that you may have to pay for it?
Kim Paull: Yes. We wanted to reflect what is on the site now what is most useful to the public.
Senator Izzo: You can see what is patient X for all these procedures, but you cannot use it to see who person X is to intervene?
Ann Martino: No, it is not designed to work as a management tool.

Sharon Terzian: Does it include kids too?
Kim Paull: Yes all ages.

Maureen Maigret: So when would some information be available on the website?
Kim Paull: It is now, on the website – there is data on ED visits – health.ri.gov/facts
Lynn August: For level three you can get to the member individual level?
Kim Paull: Yes but no name, no address, so SSN etc.
Ann Martino: One of the things we struggled with was trying to determine whether it was the type of care being provided by the provider, or if it was a function of the kind of people who were there, there level of acuity, but we could not track them across all payers before. This is truly phenomenal as you can actually build an electronic record of all the costs for a particular group.

III. Ongoing Initiatives

a. Children's Cabinet Update – Dacia Read
   Dacia Read: I am the policy director for the Children's Cabinet which the Governor reconvened in July. It was not meeting for a while, the Governor brought the Children's Cabinet up in July, I came in in October, and a strategic plan released in December. Primary strategy is really as a governance body to leverage information from our data,

and task forces around the state like this one, and make decisions that are informed and can really impact the system. We have director level participation, from HHS, but also Education as well, and Administration. Two goals one is around unified budgeting, and identify where there is room for other types of efficiencies for care for kids, but also to think about where we can share our data differently and package our system differently. Goals: physical health and safety (DOH, RI Housing); behavioral health (EOHHS agencies and RIDE); Academic preparedness and career readiness (WIOP – workforce innovation and opportunity plan); supporting stable families and communities (DHS pilot to support this idea at this time). Those are the broad brushstrokes, three initiatives we are working on are children's behavioral health, children in DCYF transitioning to home services, WIOP state plan. We also have our budget project – to work in a unified way we need to know where we are, so we have already taken a look and saw that we have over three hundred different funding streams for these programs, and now going forward wan to see where the opportunities are around that for efficiencies. Then on the data side – wanting to convene a data advisory council to the children's cabinet soon. The Cabinet meets the last Monday of every month and all are open public meetings.

Senator Izzo: One related issue discussed here, the transitioning of kids from children care to adults, it has long been plaguing the group. Years ago we had to identify priority initiatives we wanted to see addresses and that was one in particular. Is it before the Children's Cabinet?
Dacia Read: Transitions specifically around populations with intellectual disabilities and aligning with the consent decree – is a conversation is definitely happening. Then there are also requirements for transitions between DCYF and BHDDH and we are in the process of mapping what supports and services are happening and where it touches folks around the line. If you have previous conversations in this setting we are happy to talk about that more.
Senator Izzo: If we could get an update as often as reasonable/possible that would be much appreciated.

Ann Martino: It is true that what has happened in changes in administrations the interpretation of when a child becomes a client of BHDDH – which definition has changed. Are you looking structurally at the institutional obstacles to change?
Dacia Read: That was the cabinet's request – the process map, but to include governance recommendations - very aware that is a part in a child's life that doesn't happen in a compartment, and currently we deal with it as such. Do want to hear concerns from many sources to get a good sense about it.

Senator Izzo: One of the frustrations has been over all the years folks have been able to define an see the obstacles but no one has had the authority to make the changes. While I think folks continue to have a great willingness to be involved and collaborate, I think from my perspective the issue is we keep looking for that authority that makes the parties solve the problem. That is really in the Cabinet's court to solve that.

Ann Martino: And the legacy of this change which really began when DCYF starting service children up to age 21 it became a real problem. Kids 18-21 do not go into our adult managed care plans for example.
Dacia Read: I am intrigued by that authority of need for the cabinet's recommendation to make the change; right now is a period of getting it all together again, and connected in an intimate way, bring it back up with the cabinet to help align the thinking and then make the right recommendations.

Sharon Terzian: To Ann's point, now that my daughter is 22 it is a moment we don't really want to jump into adult services for our child. There are few parent consultants around who do not have access to Hasbro who are being put into Miriam. I don't know how to fix it, but it is a struggle. It's bigger than just that.
Dacia Read: Thank you for sharing, and I will connect with you when we wrap up here to learn more.

Ann Mulready: I cannot always get to the Children's Cabinet, so it would be helpful for us to have a way to have some input. As important as it is to work out DCYF to adult transitions to youth with behavioral health and developmental disability needs, the vast number of those kids are not DCYF children, so for families with youth with those needs need to change out of those. The frustration of families who are trying to navigate it on their own is getting really difficult. Having RIDE involved is very important.
Dacia Read: There may be other topics over time to keep to come back to you all with that, but for now there seems to be saturation on these issues, and I can come back to you all with more of focus on this as we structure our environmental scan to be sure we have all the issues on this. Any other comments/issues you would like to share? If you cannot make our meetings, feel free to visit our website and put your ideas into our box.

Senator Izzo: You the liaison now for us for the Children's Cabinet.
Dacia Read: Yes and I work for EOHHS.
Senator Izzo: The spectrum of interest is definitely beyond DCYF.
Dacia Read: Absolutely.

b. **Office of Program Integrity Initiative Update - Ralph Racca**
Ralph Racca: I am an administrator in the office of program integrity. I am here today to update you on the Reinventing Medicaid initiatives that we are involved in. Predictive modeling and analytics software – we are just standing this up and getting it online and realizing there is a lot of information out there and how we use it to be sure the information is valid. There were some claims coming in and there were some issues with the data, and we are working with the insurers to correct the claims and the data. With the Reinventing Medicaid initiatives we were able to combine enhanced residency verification with our predictive modeling analytics to significantly reduce our incorrect mail issue, and returned mail to work to get folks their anchor cards if there are false/unverified new addresses that may have happened in the last few months. We

are able to combine two in one – the type of gift that will keep on giving, social networking with the providers, and how that works with the individuals that we service. It was 2012 that we started this, ten proposals, but we have a great vendor with experience in Massachusetts and it is working well. Bouncing information off of that.

The second initiative is Electronic Visit Verification (EVV), an electronic attendance system, we started it prior to Reinventing Medicaid, but then were able to dive into it further. It was a weakness in our system in the past – line up services from providers to our clients in a timely fashion. We are setting up information meetings this week – not a training session, but a high level view to understand the program, what our goals are – to have solid input back prior to our beginning the program. We are aiming for June as a launch date.

Another initiative that we tied to this is a Home and Community Based Services (HCBS) audit for all our home agencies in the state. Program Integrity is about fraud, waste and abuse. We do not have a lot of fraud, but we keep an on waste and abuse – are you billing appropriately, are you maintain the right documentation in your office, so that we come in and audit you it is there. If it is not documented it didn't happen – we do this for all our providers across the board.

Maureen Maigret: Can you explain how EVV works?
Ralph Racca: It is a system with a vendor who has a software package, the provider will submit claims to the vendor for prior approval. We, as the payer, will submit our recipient file to them, our provider file to them, and our authorizations to them. Once they have that information, when a provider submits a claim, the vendor will screen it to verify, they will then approve the payment, which then comes to us as the payer and is adjudicated by our payment system.
Ann Martino: Important to note it is not authorization in that you cannot get the visit without authorization, this is about payment only.
Ralph Racca: There are certain benefits to the providers – there is a time keeping feature in the system, there is a scheduling system – we will get into that with the providers in those information session the next few days. As with predictively modeling, RI is an early adopter. We have a great staff working on this.

Lynn August: Is this provider to Medicaid, or Provider to Managed Care Organization (MCO)?
Ralph Racca: Initially rolling it out in the FFS world, talking to the managed care organizations about adopting our system eventually so it could work for all Medicaid clients regardless of where they are.

Senator Izzo: If a person goes in, it is pre-approved, the provider bills, the EVV states that it is not cleared, then doesn't that mean the provider has to track declined payments? Do they have to go through an appeal?
Ralph Racca: The claim, before it comes to Medicaid, will go through the vendor system

– if there is problem with what is submitted to the vendor due to a match up on data or authorization – that claim will be rejected electronically and the provider can submit supplemental information and then quickly update the claim for data.

Nicholas Oliver: For the group it would be helpful to explain how each individual visit is verified?
Ralph Racca: Each is verified by the caregiver who goes into the home – one of three ways: call in via land line with voice identification; a smartphone, there is an app that the caregiver can use, with GPS information, and that is put in, or there is a small device that prints out a code, and if someone doesn't have a land line, or the caregiver doesn't have a smartphone then there is a device in the home that the caregiver will input a code in to get the data in there. There will be a learning curve but we are working to provide options to make his easy to get on the road.
Ann Martino: We had to do something similar in child care about a decade ago – it did initially seem like an onerous set of steps – but we did it voluntarily in RI, and then six years later the federal government mandated it. The emphasis is on fraud – if you look at where the dollars are in Medicaid there is a perception that there is widespread fraud from the national level, and we are working to clear this.

Ralph Racca: I encourage everyone to come to the meetings this week - the information sessions, Thursday and Friday mornings, and we will be setting up a webinar. We do want to meet a timeline. Last initiative that we inherited that I would like to speak to today was Medicare/VA identification: better ways to identify folks who are entitled to Medicare benefits, or VA benefits who are on the Medicaid program who could be eligible for VA benefits. We went out to bid for this service, we received two proposals that came in last Thursday and are beginning the review process on this. A way to see if we are primary when we should be secondary. Many may have Medicare A & B, but they apply for HSRI, they can get MAGI coverage, realize that they can save some money per month and they wrongly drop their Medicare. The intent is to correct those.

Kathleen Kelly: When you referred to the analytics is that the same analytics that Kim was talking about?
Ralph Racca: Not the ACPD, but yes we work with Kim on the data to do better residency verification.
Kathleen Kelly: Regarding EVV, is Assisted Living included?
Ralph Racca: No, the onus is on the home care provider.

Nicholas Oliver: The home care audit, the last audit was a significant document audit, not a financial audit, requested significant employee info, visit info etc. The providers were given the information to comply with this audit over the holidays but the purpose or intent was not made clear.
Ralph Racca: We were looking at it as a compliance audit. Are the services being provided by the appropriate party; we have CAN, we have homemaker, and there are different rates there and we need to be sure that we have the information on. It is a

compliance audit to be sure that we are right too.
Ann Martino: We do this in so many places too.

Nicholas Oliver: Are you looking to refine what the combined care policy will be and how we can seek reimbursement for combined care moving forward?
Ralph Racca: No the purpose of this audit was a compliance audit and we learn as we do the audit. The process we will follow is to notify the various agencies of our findings, given them a chance to meet, to agree or confront findings and mediate from there. As long as there is supporting documents
Nicholas Oliver: So there will be responses to the individual providers? What's the timeline?
Ralph Racca: Good question, it's a lengthy audit – we are about two thirds completed, and we have that audit and EVV. We want to get the information out on EVV first and then will be communicating out to providers further on the audit. Try to temper the work, make it reality based in the process. I would say a response within the next several months.

IV. Legislative Update

a. **Legislation 2016 – Michael Cronan, EOHHS**

Michael Cronan: Good afternoon, thank you Mr. Chairman, and to Dr. Martino and the Secretary. I am handing out a packet here that we can send along to anyone who would like via email.
Mr. Cronan goes through the handout talking about budget articles relevant to EOHHS briefly, and will take questions as arise.
Ann Martino: Mike and Deb George (Chief Legal) they meet weekly with representatives of EOHHS as well as folks from OHIC and Governor's office and go through each area of legislative for where it may have a direct impact on each agency and their cross cutting affects. That is the purpose of that group as we work to coordinate and develop plans together.

Nicholas Oliver: Has the administration taken a stand on the Sapinsly Compassionate Care Act?
Michael Cronan: I do not know but I can find out – last year there was no comment made when it was introduced.
Sharon Terzian: My daughter is on a treatment that is thousands of dollars every time she goes for that infusion and another version of it is even more money. This Senate bill to suggest creating a critical prescription drug list and require financial disclosure by drug manufacturers is an issue.
Ann Martino: Absolutely – that's so hard. The question is though once we require them to disclose the cost, what is the next step? We are limited in terms of what Medicaid can do, as we already have a generic-first policy for all of our Medicaid programs.

Ann Martino: Senate Bill 2521 is a pass-through for nursing facilities which is not yet in the Governor's budget. The home healthcare pass-through is in Article 9 section 7.

Maureen Maigret: A couple of bills here you said have been introduced before – the ones that talk about disregards – the purpose of those is to increase the number of low income people who are eligible to have it paid for by the Medicare premium program.
Ann Martino: While we support the concept we do not have the funds available to do this yet.
Maureen Maigret: Right, I know that, but it would help a number of seniors who are resource limited.

Kathy Heren: Where is the bill we see every year that allows patients to sue the nursing homes.
Michael Cronan: I need to look further to see if it is folded in – I will go back and then give you a call tomorrow on that.

Nicholas Oliver: What is EOHHS stance on telemedicine?
Michael Cronan: We support telemedicine, we have some Reinventing Medicaid initiatives that would underscore that view. There is a tele-psychology bill that is in there now.

Senator Izzo: We will see you again before end of session?
Michael Cronan: Absolutely.

b. **Levels of Care Changes Update – Ann Martino**

Ann Martino: I am going to give you an update on a few things, to start, a draft of new rules on LTSS in the new world. We are also looking at providing greater detail – when we looked at the comments on rule 1500 most of what we heard was a call for further detail and that is forthcoming. The second thing is that we indicated to you all that Office of Medical Review was conducting a study to see if one of the four criteria for determining a need for high vs highest level of care was any different and so far no difference. At this time we will go forward using both sets of criteria as a pilot and then report back to see if there is any difference. Thus far there has been no difference in terms of level of need which does address some of your concerns. Some other items that have come up, what would happen if someone came in at highest level and they got better, and we are looking at those issues. By our next meeting we will have an update on the rules there. In terms of levels of need we will be, as I said, treating it as a pilot to be sure there is no adverse impact.

Jim Nyberg: At the last meeting you said the criteria was on hold with CMS?
Ann Martino: Yes – CMS has no problem with us going forward. The LOC waiver request can go forward as a category two, and the state will determine whether or not to go forward based on the results of our assessment in this study. We will be back to you with more detail in the near future. There are four criteria that we use to determine have the highest need for nursing home level of care. We changed one of the four criteria, did not touch the other three. At this point we are not seeing an appreciable difference as a result, but we will continue to study. Also looking at the mechanism for

evaluating work at 30 days, and 45 days to see.

Ann Mulready: It may not matter in terms of what the state is doing right now, but the state has the ability to create a waiting list for community services and supports?
Ann Martino: You are always eligible to receive community services and supports, but you may be on a waiting list for certain services and supports based on needs.
Ann Mulready: Is that not the point, if you are not the highest level of care then the state may limit service?
Ann Martino: They have the right to limit the amount, but not access to the service. We cannot deny you the service, cannot deny access to a specific service that we cover under the state plan or the waiver. You could be put on a wait list for Assisted Living, but you would get those services that are a part of Assisted Living, but perhaps not in the Assisted Living of choice.

Sharon Terzian: The other tier levels too I have to appeal every year for my child.
Ann Martino: Right – that is a different level of tiers, but we have not touched those this year. We are talking about nursing homes at this point.

Virginia Burke: We were concerned only about the LOC one as that is the one you are changing. In the pilot study you do, if you say that most of our patients meet most of the other three, maybe look at the other ones who are qualifying under functional impairment standards so as not to dilute the data.
Ann Martino: Yes, we are aware and that is our intention.
Virginia Burke: Did you find any other state that uses these standards?
Ann Martino: As a whole, if you look at it, we are consistent with national standards. Other states do other things that we do not – some move people out at 30 days and we do not, some impose a life lien, etc. We do not. Before we do change we will have fairly concrete evidence that indicates where we are in terms of the whole nursing home LOC issue.
Virginia Burke: What about at the time that you developed these standards?
Ann Martino: Yes and we have discussed these before. The mistake was it was looking at Connecticut and Massachusetts and only looked at the functional set of criteria, but other states only use functional, we use functional and clinical criteria. Each state is unique – have to look at what is done as a whole. We are unique in the country which have an entitlement to HCBS through their waiver – us and Vermont. We talk about access and the bottom line is we cannot be evaluated against other states that have not that same similar type of waiver where that entitlement exists. Massachusetts has limits on the number of people who can access HCBS – we do not. If you meet this standard or that standard, and you meet the highest you get the services where you want them; if you are high then you get the services but in the community based setting. We will admit that early on our basis of comparison was wrong, but we are now making sure we study this and ensure this works for the people of RI. We will be looking closely at all the comments you all sent us and keep moving forward.

Jim Nyberg: Do you have a timeframe for this pilot?
Ann Martino: July for the end of the pilot – a decision will be made but the effective date is unknown yet.

Ann Martino: In addition I have copies of the Integrative Care Initiative draft rules - they are draft, we have not yet filed them with the Secretary of State's office. We will have an informal community meeting before we go to a formal public hearing process. This covers RHO for those without third party coverage, adults with disabilities with SSI characteristics. Also covers phase I of the ICI and people who have Medicare and Medicaid and are fully enrolled. Definitions are included in there. The last second of these draft rules are about ICI Phase II, take your time, look at it, and we will set something up for you all to discuss. We will notify you as soon as possible – we do need to file them with ORR.
Kathleen Kelly: If these are proposed rules, are you still moving forward?
Ann Martino: We are going to move forward to adopt a rule – that's why I am giving this to you now, you can review it quickly before the information session, including any major holes. We will be moving forward very quickly after that aforementioned information session concludes.

Senator Izzo: You will have the open info session, prior to our next EOHHS TF meeting, if there are any specific piece that you have questions you want to bring to this group/get a question to Ann before the meeting so that we can be focused by our March EOHHS Task Force meeting.

V. **Public Comment**

Sharon Terzian: I know the director brought up that they would bring 300 people out of group homes by March 1, 2016 and I would like an update on that?

Ann Martino: That is something that we can bring up with BHDDH and our March EOHHS TF meeting.

VI. Adjourn